

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. Gen. Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Mo. & 4 days
(Specify whether
In this community 22 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3015 East 6th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME JAMES O. DANIELS 562

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ruth 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Jan 1, 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 3 7 hr. min.

9. Birthplace Ill. U.S.A.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name Henry Daniels

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hall

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Lulu Daniels
(b) Address 3015 E 6th K.C. Mo.

17. (a) Burial (b) Date thereof Apr 11, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope K.C.

18. (a) Signature of funeral director Wm N. Blackman
(b) Address K.C. Mo.

19. (a) Apr. 10, 1940 (b) M.M. Crave
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th
year 1940 hour 11 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from 12-4-39, 19____, to 4-8-40, 19____;
that I last saw him alive on 4-8-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Amputation of right leg, mid femur

Due to Osteomyelitis

Due to Auto Traumatism

Other conditions Right upper lobe lobar pneumonia
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy See above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Acc.
(b) Date of occurrence April 4, 1939
(c) Where did injury occur? 710 W. Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Pedestrian Auto Accident
(Specify type of place) (e) Means of injury _____

While at work? _____ (e) Means of injury _____

23. Signature W. De Maria M.D. (M. D. or other)
Address Supt. K.C. Gen. Hospital, K.C. Mo. Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. D. Blackman

Licensed Embalmer No.....

3639

P. O. Address.....

K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.